Ontario

Ministry of Health

Report, Reaction, Response

The Health Care System in Ontario

A review of the reaction to the Report of the Health Planning Task Force and a summary of common ground on which health care strategy can be advanced

Report, Reaction, Response

Contents

Task Force Established

In January 1973 a Cabinet Directive of the Ontario Government established a Health Planning Task Force to develop proposals for a comprehensive plan to meet the health needs of the people of Ontario.

Dr. Fraser Mustard, Dean of the Faculty of Health Sciences at McMaster University, was appointed chairman of the task force. Other members came from the health professions, hospitals, universities and the field of economics, together with senior officials of the Ontario Ministry of Health. The Task Force met regularly during 1973 and its report was submitted to the Ontario Government in January 1974.

The need for Reaction

The report of the Health Planning Task Force was carefully studied by the Ontario Government. It was apparent that this comprehensive report highlighted many of the weaknesses of the health care system in Ontario today, and offered enterprising approaches to their solution.

On the other hand, not only was some doubt felt whether these approaches would in all cases prove practicable, but the report contained genuinely controversial proposals on which sharply divided opinions would be held — even by those not directly affected by their adoption. Taken as a whole, it could be seen that these proposals would inevitably bring about fundamental changes affecting roles, structures and practices at all levels in the existing health care system.

Since the Ontario Government is committed to the principle of public involvement in the planning and delivery of health services, it was decided that these proposed changes were on too wide a scale to be contemplated without the understanding, co-operation and support of the public, health professions and health agencies.

In consequence, the Report of the Health Planning Task Force was published in April 1974 as a Green Paper — that is, as a document intended to elicit discussion and debate — and considered response was invited.

The Approach to Response

In the words of the Honourable Frank S. Miller, Minister of Health, "We want to make sure that these are the issues, and these the best ways of approaching them. Also, we want to find out whether these proposed solutions are the right ones, or whether there may be other equally valid or better answers."

As had been expected, response took time. The report itself had taken a year to prepare, it contained many far-reaching proposals, and it was necessary for those interested to make a complete and impartial evaluation before submitting their comments. In all, 611 responses were received from professional organizations, institutions, municipalities, universities, public and voluntary agenices, from individuals associated with health care delivery, as well as from community and church groups and members of the public. Comments were also received from Ministry staff. All of these were carefully read and individually studied before an overall analysis was started.

In its analysis of the Report of the Health Planning Task Force and the reaction to it, the Ministry was able to group the 12 Task Force recommendations into six broad fundamentals.

The Ministry grouped the Task Force's recommendations into six fundamentals

Fundamentals	Specific recommendations
I Development of primary care sector	1 Provide continuous primary contact service (#1)* 2 Organize in primary care groups including allied health professionals (#6) 3 Promote through special operating funding arrangements (#9) 4 Provide many of the functions of the public health units through primary care groups
II Rationalization of secondary care	1 Provide consulting and advisory service for the primary care sector (#2) 2 Organize and rationalize around programs within districts (#2) 3 Compensate at specialist rates only for referred, specialist services
III Local involvement in health service planning by district and area (#3)	1 Set up Health Councils at district level to recommend plans for the delivery of health care (#4) 2 Legislate Health Services Management Boards at area level for management integration of institutions, administrative support to other programs (#5) 3 Set up professional advisory committees to DHC at area and district (#1, 2)
IV Redefinition of responsibility in the Ministry	1 Appoint Regional Directors with authority and staff to act for Ministry (#7) 2 Increase prominence of Research, Information and Communications (#8) 3 Assume leadership in co-ordinating research programs of the province (#12)
V Greater involvement in manpower planning and control	1 Introduce manpower establishments for various categories of health professionals through District Health Councils (#10) 2 Steer clinical education programs for improved balance between primary and secondary care, use full range of community facilities and services (#11)
VI Improvement in the delivered quality of medical care	1 Organize and make more comprehensive peer evaluation to maintain quality of care (#1, 2, 4, 5)

* (Numbers in brackets refer to specific recommendations of the Task Force)

Fundamentals of the Report

The *first* fundamental in the report is the development and strengthening of the primary care sector as the front line of an integrated, comprehensive health system. As the Task Force said, "primary care includes not only those services that are provided at first contact between the patient and the health professional, but also responsibility for promotion and maintenance of health and for complete and continuous care of the individual ... and is provided most effectively through group arrangements."

The *second* fundamental of the Task Force's revised health system is an integrated and co-ordinated secondary care sector, acting as a resource to primary care. Secondary care is seen as requiring "specialized skills and facilities not available in the primary care". Strengthening secondary care would involve the planning, improved co-ordination, and eventual rationalization of delivery of secondary care services on a provincial, regional and local basis.

The *third* fundamental of the Health Planning Task Force is that health services must be planned and co-ordinated at the level at which they are delivered — the local level — and that the mechanism to bring this about must be locally based representative bodies. The Task Force believed that "community input will be increasingly important in determining which new health services should be introduced and which existing services should be modified."

The *fourth* fundamental is concerned with re-defining responsibility within the Ministry. The Task Force felt the Ministry should be re-structured to "achieve optimal use of the (District Health) Councils and to permit full implementation of our proposals for the health system. The key to the new structure is the establishment of a system of regional offices to serve the districts throughout the province." The Task Force also recommended revisions relating to a Research and Development Division, an Information Service Division and the Communications Branch.

The *fifth* fundamental is that there be greater public involvement in the planning and control of the distribution of health manpower. District Health Councils "would decide, within provincial guidelines, the number of positions to be established for various categories of health personnel, according to district requirements."

The *sixth* fundamental encompasses a number of specific recommendations made by the Task Force to improve the delivered quality of medical care through the establishment and operation of evaluation procedures, based on an audit of health services, and a review of the performance of health personnel by their peers in the primary and secondary care sectors, as well as the development and monitoring of mechanisms to ensure the quality of care within institutions.

Report, Reaction, Response

The first three — the development of the primary care sector, rationalization of secondary care, and local involvement in health service planning — form the foundation for the most significant changes the task force felt were needed in the health system.

On these fundamentals, a consensus has emerged. There is agreement among groups outside the Ministry and this agreement coincides with the Ministry's analysis of what is required to improve the health system.

The next three — redefinition of responsibility in the Ministry, greater involvement in manpower planning and control, and improved delivery of medical care — were not subject to the same degree of comment, or consensus.

However, it should be pointed out that while there was a thread of consensus on the fundamental principles of primary and secondary care, and on community involvement, there were many areas of concern, questions, problems and outright disagreement with individual recommendations at the detailed level. In fact, concerns or disagreement emerged regarding one or more aspects of all but the last of the six fundamentals — improving the delivered quality of medical care.

The following pages contain an outline of the report ■ , the reaction ● and the Ministry's response ▶ .

I Development of primary care sector

In the *first fundamental*, developing the primary care sector, the Health Planning Task Force suggested four specific requirements:

1 continuous primary contact service, including 24-hours-a-day, seven days a week coverage;
2 the development of group arrangements that include physicians and allied health personnel;
3 the development of special funding arrangements to support the team approach to primary care; and
4 the assumption by the primary care groups of the personal care services of public health that relate to the promotion and maintenance of health.

■ 1

The first recommendation was that the primary care sector be organized to provide continuous care. There were two elements to the concept of continuous care. The first was that the primary care group should be concerned with the continuing well-being of its patients including prevention, health promotion, health maintenance, consultation, education, diagnosis, treatment and rehabilitation. The second concern was that primary contact service be available on a 24-hour basis.

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In relation to the first requirement, that primary contact service be continuously provided to the public, there was near unanimous agreement that continuous care is desirable. The second aspect of continuous service — 24-hour availability — however, raised a great deal of concern about how practical this concept would be in many communities where the population is not of sufficient size to warrant standby personnel at all times.

▶
The Ministry agrees there is a need to strengthen and develop the primary care sector — to provide a continuous concern for the patient's well-being and to co-ordinate care as it is provided through the health system. It is concerned that the people of the province have available to them health care when they need it, realizing that their need may not, and frequently does not, fall within normal office hours. On the other hand, the Ministry is fully aware that the province could not support the number of health professionals necessary to provide every community with standby health professionals of all descriptions at all times. We believe that appropriate organizational and information arrangements are required in each community to ensure that continuous coverage is accessible at all times.

■ 2
The second requirement of this broad area was concerned with group arrangements for primary care. The Task Force considered a team approach to health care delivery, including a range of health manpower, a key element in its proposal.

●
Again, this concept was widely supported, with the primary concern of both the health community and the public being that any team approach should not interfere with the patient's access to the doctor of his or her choice.

▶
The Ministry is very sympathetic to this concern. We feel that the answer to it lies in the establishment of many kinds of group arrangements. This will permit both direct doctor-patient contact where that is needed and desirable, and the use of a variety of health personnel where this is appropriate. We believe this combination of advantages is now working in a number of group practices throughout the province, and is therefore attainable. The Ministry is testing and studying a number of alternative arrangements that will permit allied health personnel to work along with the primary care physician.

■ 3
The third requirement the Task Force suggested to strengthen primary care was the development of special funding arrangements to facilitate the team approach.

●
Most health professionals supported experimentation with alternatives to the fee-for-service system, but all were insistent that the existing fee-for-service option be retained until the new methods have been thoroughly tested and evaluated.

Another concern from the health community was that financial incentives — primarily for the development of appropriate capital facilities — would be required to implement the group arrangement suggested.

The Ministry is in complete agreement with developing alternatives to fee-for-service, is currently testing a number of them, and will continue to do so. Through a special project group, the Ministry has been testing alternative compensation arrangements of various kinds including salaries, global budgets and capitation. (Capitation is a system where the primary care group is compensated with a fixed sum for every patient taken care of on a regular basis.) The purpose of these arrangements is to give clinical practitioners more flexibility in using those health personnel they feel are most appropriate, given the health needs of their patients, than is possible under a fee-for-service system. One group, for example, added a social worker to its team after a capitation arrangement had been made with the Ministry. Other groups are using nurses and other health workers in a variety of ways to increase the productivity of the whole health team.

The Health Planning Task Force did not touch on financial incentives for the development of capital facilities for primary care. As a general rule, health practitioners provide for their own capital facilities and are reimbursed as they provide services. The Ministry does not feel there is any need at this time to make a substantial change in that position.

4

The fourth requirement was that the primary care sector should assume responsibility for personal-care aspects of the public health units.

This concept was rejected by a wide range of respondents, including practising physicians and public health personnel, as well as consumer groups. It was felt that in the past, the combining of treatment services with preventive services usually resulted in a decrease in the amount of time devoted to prevention. The alternative suggested was that public health personnel could be attached to primary care groups and provide their public health services, but retain a primary identification with the public health and preventive sector of the health services.

This is one of the areas where the Ministry gained a great deal by getting the views of health professionals and consumers. Particularly impressive was the broad cross-section of respondents who expressed concern about this aspect of the report. The Ministry can now state that it has no plans for relieving public health units of responsibilities for personal care services.

Impressive initiatives have been taken by health units in many parts of the province in the past few years to co-ordinate their personal health services with those of group practices — a need expressed by the Task Force — while retaining an emphasis on prevention. This has been accomplished through the secondment of public health nurses to group practices; there are more than 100 examples of such initiatives.

II Rationalization of secondary care

The second fundamental in the Mustard Report dealt with the rationalization of secondary care. The requirements seen as necessary to accomplish this were:

1 provision of consultative service for primary care;
2 organization by programs within the individual districts; and
3 no remuneration at the specialist rate for unreferred patients.

1

The first requirement was that the secondary care sector be oriented to act primarily as a resource to the primary care sector, with patients entering secondary care by referral from primary care. The health problems of patients seen in the secondary care sector would, then, be those that require specialized skills and facilities not available in the primary care sector.

Implementation of recommendations in the secondary care area would be complex and difficult. Many of the reactions from the health community pointed out the difficulty of attempting to impose any rigid boundary between primary and secondary care. For example, many specialists who could be considered to be part of the secondary care sector, in fact operate primarily as general practitioners or family physicians. Similarly, many services performed in hospital — which some considered to be a part of secondary care — are in fact services that fall within the primary care sector.

The Ministry is concerned that the development of a rigid separation between primary and secondary care sectors might prevent patients from going to the doctor of their choice. The Ministry feels it is neither necessary nor desirable to impose any rigid definition or to establish any rigid boundary between sectors. These are areas that will have to be carefully worked through in an evolutionary way in local communities, bearing in mind local as well as other available resources and the health care required. The important consideration is that the resources of the community be organized to ensure continuous, co-ordinated service.

2

The second requirement for rationalizing secondary care was that secondary care programs be organized to facilitate the effective use of all available services and facilities.

The Ministry was pleased to note that this recommendation, which will require some modification to the current practice, in many communities, of restricting doctors to practise in one or a few institutions, received a high level of acceptance in the health community, both in the hospitals and physician groups.

The Ministry has encouraged, and will continue to support, community initiative in rationalizing secondary care programs to improve delivery of health care for the community — to meet the needs of the community in an efficient and effective manner. At this time, and with the financial pressures created by the very high and growing cost of health care, it will be working actively with communities and hospitals to ensure that costly, unnecessary duplication is eliminated.

3

A third requirement suggested by the Task Force was that remuneration arrangements for specialists be adjusted so that the specialist fee be paid only for referred patients. This was felt necessary to encourage the use of specialists as consultants to the primary care sector, reather than as primary points of contact with the public.

There was some agreement with this suggestion, if the differential in the fee could be billed back to the patient who preferred to go to the specialist directly, rather than through his family physician.

This is an area of considerable concern to the Ministry, and is under review. On the one hand, the billing of an extra amount to the patient could be a deterrent to the patient's right to see the physician of his or her choice, while, on the other hand, it could reflect a principle of compensating specialists only for specialist services, and not for general services that could be more economically delivered by the primary care sector. The Ministry is also attracted to the idea that patients who desire the extra level of service implied by dealing directly with a specialist, rather than a primary care physician, should be prepared to pay a premium for it. However, it is also aware that in some communities, and for some people, the local physician may be a specialist and the imposition of an additional fee for what has been a normal "family doctor" relationship might be seen as discriminatory and unfair.

III Local involvement in health service planning

The third fundamental was that there be a greater local involvement in the planning and co-ordination of health services at the local level. Requirements seen as necessary to achieve greater local involvement include:

1 setting up District Health Councils;
2 establishing, by statute, Area Health Services Management Boards; and
3 organizing professional advisory committees.

■ 1

The first requirement for improved local involvement should be the establishment of District Health Councils throughout the province. (These Councils have responsibility for the "development of policies and plans for the delivery of health care within the District.")

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This is a recommendation that received widespread support from the health community and public groups. There is and continues to be considerable discussion about the specific powers, the membership and the boundaries for such District Health Councils.

▶

The Ministry is conscious of the continuing debate District Health Councils have created since they were proposed several years ago. It is gratifying that the concept is now well accepted and discussion is centering on specific aspects of implementation — boundaries, membership, specific powers. In the past year, four councils have begun to operate — in Ottawa, Thunder Bay, Niagara Region and Cochrane District. Several more are prepared to start and will be announced shortly. Throughout most of Ontario, Area Planning Co-ordinators are working with local steering committees to move more councils to an operational status. The Ministry's recently published booklet, "Action Centre in Ontario's Health Care Delivery", contains general guidelines for people involved in the formation of a council. And the Council of Health has established a Task Force to *prepare a detailed report on organizational and functional options available to District Health Councils.* This report is to be available later in the year. In sum, the Ministry is moving ahead on District Health Councils as fast as local communities want them.

■ 2

The second requirement was the creation and establishment by statute of area health service management boards. (These boards would have responsibility for a "logical grouping of facilities and administrative resources.")

This recommendation proved to be the most contentious and controversial of all the proposals of the Task Force. It attracted the widest response from the general public — all opposed. It was also totally rejected by a large number of health professional groups, because it was considered to represent the imposition of a new layer of management, replacing what was seen to be the great community strength of the voluntary hospital boards. A few groups supported the idea if it were to be a voluntary association of facilities and services, rather than imposed.

The Ministry is concerned about the Area Health Services Management Board concept and the widespread opposition to it. The Ministry sees a great deal of validity to the argument that a grouping of facilities could lead to improved co-ordination and efficiency. And it must take whatever action is necessary to bring health costs under control. However, the Ministry concedes that imposing such a grouping, in the face of complete opposition of the public, would be both unproductive and undesirable. Therefore, the Ministry will not be bringing forward legislation to impose these boards by statute. It will encourage and support the development of local mechanisms for achieving economies through co-operative activities, however, under the leadership of the District Health Councils.

3

The third requirement was the establishment of a network of supporting committees to the Area Health Services Management Boards and the District Health Council. These Health Services Advisory Committees would ensure the involvement and advice of health professionals at area and district levels.

Many groups and individuals who responded to the report were concerned about the number and layers of committees this might entail, pointing out that the benefits would not be commensurate with the time and cost.

The Ministry's approach to this problem is to encourage communities through their District Health Councils to develop whatever advisory and support structures they feel are necessary and desirable to meet their own particular needs within the conditions imposed by their own community.

IV Redefinition of responsibility within the Ministry

The fourth fundamental outlined by the Task Force was that responsibilities within the Ministry itself should be redefined. The requirements included:

1 appointing regional directors;
2 increasing prominence of research, information and communications; and
3 assuming leadership in co-ordinating research programs in the province.

1

The most important of their recommendations in this regard was that Regional Directors be established for the various parts of the province, having substantial executive responsibility in order to ensure that Ministry decisions could be made as close as possible to the community.

This recommendation caused a great deal of concern in the health community, who saw it as the imposition of a new layer of bureaucracy between the health community and the Ministry, rather than as a device for facilitating effective decision-making.

In its recent restructuring, the Ministry has been mindful of these concerns — one of the objectives of the reorganization being to improve its ability to relate to clients in the field — and has not created a decentralized regional structure. It has, however, retained the Area Planning Co-ordinators as focal points for communication between the Ministry and the various regions of the province and it is working to improve the regional sensitivity and responsiveness of other parts of the Ministry.

2

A second requirement was that research, information and communications of the Ministry should be made more prominent.

These recommendations did not elicit a large number of comments from the health community. Those that did comment were generally in agreement with the Task Force.

The Ministry has increased the senior-management attention being paid to both research and information, through the creation of a new group under an Assistant Deputy Minister with responsibility for research, development and information systems. It also continues to emphasize the role of communications in the promotion of improved health habits.

3

The third requirement identified by the Task Force was that the Ministry assume greater leadership for the co-ordination of health research in the province.

While this was not an issue that was widely commented upon, most groups associated with health research did comment and generally agreed with the recommendations.

The Ministry is currently working out new organizational arrangements and distributions of responsibility in the research and development group to accommodate these, and other, concerns.

V Greater involvement in manpower planning and control

The fifth fundamental of the Task Force Report was that there be greater involvement in the planning and control of the distribution of health manpower. The two main requirements were:

1 restricting OHIP registration to those practitioners who are approved on the establishment set by District Health Councils; and
2 steering the education system to produce more trained manpower for the primary care sector.

1

One of the most contentious requirements seen by the Task Force was that the District Health Councils should decide on the number and types of physicians required in their districts, and that the approval of District Health Councils would be necessary before any health practitioner could be registered with OHIP.

This recommendation elicited very strong concern from many sectors. Not surprisingly, the physicians disagreed with the recommendation. However, it was also noted that consumer groups objected to the human rights implications of government taking such strong action to restrict the areas in which professionals could practise.

The appropriate distribution of health manpower to ensure access of all Ontarians to high quality health care is a continuing concern of the Ministry. The approach suggested by the Task Force to ensure appropriate distribution is a particularly strong one, and one that gives rise to a great number of complex concerns. Many of these concerns were expressed in the briefs that discussed this topic. The Ministry feels that this action is not required at this time. The underserviced area program has been very successful in using incentives rather than sanctions to bring practitioners to underserviced areas. The Ministry will be encouraging District Health Councils to work with the Ministry to plan the health needs of communities, thereby identifying specific instances of maldistribution of health manpower for which specific remedies can be applied.

2

The second requirement for greater involvement in manpower planning and control was that the clinical education for all health practitioners must be steered in such a way that both primary and secondary experiences be included.

Most practitioners agreed with the need for stronger primary clinical experiences for graduates of health education programs to strengthen the primary care sector. Many groups cautioned, however, that these new clinical experiences should not be added at the expense of what is seen to be a very strong and successful secondary care clinical experience.

Earlier reports of the Council of Health pointed out to the Ministry, and to the health community, this real need for a greater emphasis on training for primary as well as secondary care. The Ministry has been working with the five health sciences centres to determine appropriate arrangements for clinical teaching of interns in family practice settings. Such arrangements should ensure that Ontarians will be served in the years ahead with health professionals who are well-trained in primary care.

VI Improvement in the delivered quality of medical care

The sixth and final fundamental was that the quality of delivered care be improved, primarily through an audit system for health services and peer review of performance of health personnel for both primary and secondary systems.

Many people in the health community agreed that this need exists, especially in the primary care sector. It was pointed out that peer review and audit in the hospital setting was established and normal practice already. The regulatory bodies of the health professions expressed some concern that whatever system is established must relate to the overall responsibility of the disciplinary body for the maintenance of quality of care.

The Task Force's recommendations on audit and peer review systems are an important part of its report. The mechanisms for monitoring the quality of medical care as it is delivered have been weak in the primary care sector. The Ministry will be co-operating with the regulatory bodies on systems for achieving improved monitoring as the health care system develops.

However, within the context of the report, it would be necessary to implement some of the structural changes in the first three fundamentals to introduce the kinds of improvements in quality of care they envisage.

Summation

The Ministry of Health feels that the Report, the Reaction, and the Response have been a highly productive exercise.

A Task Force of experts produced a comprehensive and, to a degree, controversial report; the public responded, taking a great deal of time, effort and care to react logically and carefully; and the Ministry of Health distilled and examined both the report and the reaction thoroughly before responding.

The Ministry generally agrees with the response. There is room for improvement and development in the health system, acting within the consensus found within the response. At this time, based on its own analysis, the Ministry is prepared to act within the consensus — there is room to move between where we are now and where the responses have told us the community is ready to move.

Much progress will accrue as a result of the report and the public's response. But the Ministry is not thinking in terms of the imposition of a rigid structure or a single way of doing things. What the task force said should be done — the concept they were trying to get across — is a good concept, but people have to work out its implementation on their own, according to the needs at the local level and with the people who are there.

In essence, then, the report of the Health Planning Task Force has provided the Ministry with much valuable information and opinion, as well as concrete proposals. In some areas, the report and the reaction have provided reinforcement to directions already chosen by the Ministry. This will no doubt be reflected in accelerated implementation of actions along these lines.

In other areas, such as Area Health Services Management Boards, the reaction has waved a warning flag, suggesting that these actions would lead to difficulties. Consequently, these areas will have to be more carefully examined, both by the community and the Ministry, before any action is undertaken.

Finally, the very welcome reaction to the Report of the Health Planning Task Force has helped the Ministry get a better sense of what the health community in Ontario is thinking. This is perhaps the most valuable element of all, because anything that helps us to understand each other better can only lead toward a better way of life for the people of Ontario.

Ontario Ministry of Health
Hon. Frank S. Miller, Minister

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